Family PACT: Treatment Authorization Request (TAR)   1

This section outlines prior authorization requirements and *Treatment Authorization Request* (TAR) completion instructions for Family PACT complication services. Family PACT prior authorization requirements are the same as Medi-Cal prior authorization requirements unless stated otherwise in this manual. (See the *TAR Overview* section in the Part 1 Medi-Cal provider manual for general TAR information.)

Overview

Family PACT complications services must have prior authorization.

A *Treatment Authorization Request* (TAR) <u>must</u> be submitted for all Family PACT complications services, including office visits, procedures, facility use, laboratory and pharmacy services.

Prior authorization must be obtained by enrolled Family PACT providers and all non-Family PACT providers who render Family PACT services on referral, including Medi-Cal clinicians, laboratories, pharmacies and hospitals. For additional information about services by referral, see the *Family PACT: Complications Services Overview [familypact13]* section in this manual.

Elective Hospital Admissions Require TAR

All elective hospital admissions require prior authorization.

Retroactive TARs Receipt Requirements

Retroactive TARs must be received within 10 working days by the Medi-Cal field office in cases of urgent or emergency situations, or for inpatient stays secondary to an urgent or emergency situation. For Medi-Cal field office information, see the *TAR Field Office Addresses* section in the appropriate Part 2 Medi-Cal manual.

Complication Services: Definition	For a definition of Family PACT complication services, see the *Family PACT: Complications Services Overview [familypact13]* section of this manual.

Outpatient Complications Services Require TAR

Prior authorization is required for outpatient services when:

- Complications are beyond the scope of the core Family PACT services. All complications services, except pharmacy, are pre-selected. See the *Family PACT: Billing Code List [familypact23 – 25]* sections in this manual.

- A Family PACT provider refers the client to a non-Family PACT provider specialist or consultant for complications.

  Note: This provider must be a Medi-Cal provider. Claims and TARs by a Medi-Cal non-Family PACT provider must include identification of the referring Family PACT Medi-Cal provider number so the system can confirm that the referring provider has Category of Service (COS) 11. (See *Figure 2*, TAR Form Example for Non-Family PACT Provider (Referred Provider) in this section.)

- Laboratory services for complications are outside those procedures established as core Family PACT procedures. Complications laboratory services are pre-selected. See the *Family PACT: Laboratory Codes [familypact38 – 40]* sections in this manual.

- Radiology services for complication services are outside those procedures established as core Family PACT procedures. Complications radiology services are pre-selected. See the *Family PACT: Billing Code Lists [familypact23 – 25]* sections in this manual.

- Medications and supplies not on the Family PACT Pharmacy Formulary are needed for the treatment of complications.

Inpatient Complications Services Requiring Prior Authorization

Emergency and inpatient care is subject to the TAR process for the hospital days and the medical services. Only services for complications of family planning methods and treatment complications for related conditions as defined by the Family PACT Program are covered services.

TAR Completion

Providers submitting TARs for Family PACT services must do the following:

- In the *ICD-9-CM Diagnosis Code* field of the TAR, document the primary diagnosis code ("S" code) related to the complication. The code will have a number 3 in the fifth place (Sxx.3)
- In the *Medical Justification* field of the TAR, document the following:
  - "Family PACT client"
  - Secondary or concurrent ICD-9-CM code when the TAR is for complications of secondary or concurrent condition treatment
  - Medical justification for the services requested
- Attach a copy of the referral from the certified Family PACT provider (for non-Family PACT provider rendered services), if applicable
- Place the TAR Control Number (TCN) on any claim submitted for TAR authorization services

Note: For additional information refer to the *TAR Completion* section in the appropriate Part 2 Medi-Cal provider manual.

TAR Examples

On following pages are TAR form examples for Family PACT and non-Family PACT Providers. List all anticipated services (including office visits, laboratory tests, procedures, etc.) to be rendered.
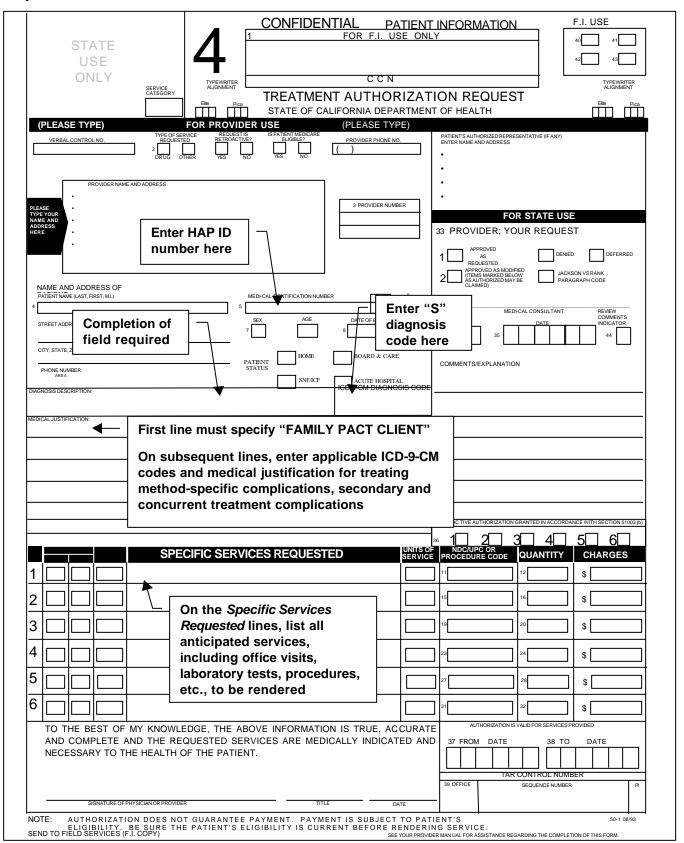
STATE
USE
ONLY

SERVICE
CATEGORY

4

TYPEWRITER
ALIGNMENT

Elite   Pica

CONFIDENTIAL   PATIENT INFORMATION

1   FOR F.I. USE ONLY

C C N

F.I. USE

40   41

42   43

TYPEWRITER
ALIGNMENT

TREATMENT AUTHORIZATION REQUEST
STATE OF CALIFORNIA DEPARTMENT OF HEALTH

Elite   Pica

(PLEASE TYPE)   **FOR PROVIDER USE**   (PLEASE TYPE)

VERBAL CONTROL NO.

TYPE OF SERVICE
REQUESTED
DRUG   OTHER

REQUEST IS
RETROACTIVE?
YES   NO

IS PATIENT MEDICARE
ELIGIBLE?
YES   NO

2

PROVIDER PHONE NO.
(   )

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY)
ENTER NAME AND ADDRESS

PROVIDER NAME AND ADDRESS

PLEASE
TYPE YOUR
NAME AND
ADDRESS
HERE

**Enter HAP ID
number here**

3 PROVIDER NUMBER

FOR STATE USE

33 PROVIDER; YOUR REQUEST

1   APPROVED
AS
REQUESTED

DENIED   DEFERRED

2   APPROVED AS MODIFIED
(ITEMS MARKED BELOW
AS AUTHORIZED MAY BE
CLAIMED)

JACKSON VS RANK
PARAGRAPH CODE

NAME AND ADDRESS OF
PATIENT
PATIENT NAME (LAST, FIRST, M.I.)

4

STREET ADDR

CITY, STATE, Z

PHONE NUMBER
AREA

MEDI-CAL IDENTIFICATION NUMBER

5

**Completion of
field required**

SEX   AGE   DATE OF B

7   8

PATIENT
STATUS

HOME   BOARD & CARE

SNF/ICF   ACUTE HOSPITAL

ICD-9-CM DIAGNOSIS CODE

**Enter "S"
diagnosis
code here**

MEDI-CAL CONSULTANT
DATE

35

REVIEW
COMMENTS
INDICATOR

44

COMMENTS/EXPLANATION

DIAGNOSIS DESCRIPTION:

MEDICAL JUSTIFICATION:

First line must specify "FAMILY PACT CLIENT"

**On subsequent lines, enter applicable ICD-9-CM
codes and medical justification for treating
method-specific complications, secondary and
concurrent treatment complications**

ACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (b)

36   1   2   3   4   5   6

	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC/UPC OR PROCEDURE CODE	QUANTITY	CHARGES
1			11	12	$
2			15	16	$
3			19	20	$
4			23	24	$
5			27	28	$
6			31	32	$

**On the *Specific Services
Requested* lines, list all
anticipated services,
including office visits,
laboratory tests, procedures,
etc., to be rendered**

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE
AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND
NECESSARY TO THE HEALTH OF THE PATIENT.

AUTHORIZATION IS VALID FOR SERVICES PROVIDED

37 FROM   DATE   38 TO   DATE

TAR CONTROL NUMBER

39 OFFICE   SEQUENCE NUMBER   PI

SIGNATURE OF PHYSICIAN OR PROVIDER   TITLE   DATE

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S
ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.
SEND TO FIELD SERVICES (F.I. COPY)

50-1 08/93

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM.

Figure 1. TAR Form Example for Family PACT-Approved Provider.

CONFIDENTIAL   PATIENT INFORMATION

STATE USE ONLY

4

FOR F.I. USE ONLY

C C N

F.I. USE

40 41
42 43

SERVICE CATEGORY

TYPEWRITER ALIGNMENT

Elite Pica

TREATMENT AUTHORIZATION REQUEST
STATE OF CALIFORNIA DEPARTMENT OF HEALTH

TYPEWRITER ALIGNMENT

Elite Pica

(PLEASE TYPE)   **FOR PROVIDER USE**   (PLEASE TYPE)

VERBAL CONTROL NO.

TYPE OF SERVICE REQUESTED
DRUG OTHER

REQUEST IS RETROACTIVE?
YES NO

IS PATIENT MEDICARE ELIGIBLE?
YES NO

PROVIDER PHONE NO.
(   )

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS

PLEASE TYPE YOUR NAME AND ADDRESS HERE

PROVIDER NAME AND ADDRESS

3 PROVIDER NUMBER

Enter HAP ID number here

FOR STATE USE

33 PROVIDER; YOUR REQUEST

1 APPROVED AS REQUESTED
2 APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED)

DENIED DEFERRED

JACKSON VS RANK PARAGRAPH CODE

NAME AND ADDRESS OF PATIENT
PATIENT NAME (LAST, FIRST, M.I.)
4

STREET A

Completion of field required

CITY, STA

PHONE NUMBER
AREA

MEDI-CAL IDENTIFICATION NUMBER
5

SEX
7

AGE

DATE OF BIRTH
8

PATIENT STATUS

HOME

BOARD & CA

SNF/ICF

ACUTE HOSPITAL

C D HIEGCIK Y

6 P

Enter "S" diagnosis code here

BY

MEDI-CAL CONSULTANT
DATE
35

REVIEW COMMENTS INDICATOR
44

XPLANATION

DIAGNOSIS DESCRIPTION:

ICD-9-CM DIAGNOSIS CODE

MEDICAL JUSTIFICATION:

First line must specify "FAMILY PACT CLIENT REFERRED BY FAMILY PACT PROVIDER" (include provider #)

On subsequent lines, enter applicable ICD-9-CM codes, medical justification for treating method-specific complications, secondary and concurrent treatment complications

VE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (b)

1 2 3 4 5 6

	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC/UPC OR PROCEDURE CODE	QUANTITY	CHARGES
1			11	12	$
2	**On the *Specific Services Requested* lines, list all anticipated services, including office visits, laboratory tests, procedures, etc., to be rendered**		15	16	$
3			19	20	$
4			23	24	$
5			27	28	$
6			31	32	$

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

AUTHORIZATION IS VALID FOR SERVICES PROVIDED

37 FROM   DATE   38 TO   DATE

TAR CONTROL NUMBER

39 OFFICE   SEQUENCE NUMBER   PI

SIGNATURE OF PHYSICIAN OR PROVIDER   TITLE   DATE

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.
SEND TO FIELD SERVICES (F.I. COPY)

50-1 08/93

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM.

Figure 2. TAR Form Example for Non-Family PACT Provider (Referred Provider).

Explanation of Form Items

The following item numbers and descriptions correspond to the sample TAR (50-1) on the previous page of this section.
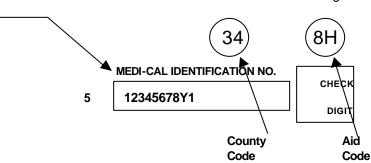
Item	Description
1.	**STATE USE ONLY.** Leave blank.
1A.	**CLAIM CONTROL NUMBER.** For FI Use Only. Leave blank.
1B.	**VERBAL CONTROL NUMBER.** Leave blank.
2.	**TYPE OF SERVICE REQUESTED/RETROACTIVE REQUEST/MEDICARE ELIGIBILITY STATUS.** Enter an "X" in the appropriate boxes to show DRUG or OTHER, RETROACTIVE request, and MEDICARE eligibility status.
2A.	**PROVIDER PHONE NO.** Optional.
2B.	**PROVIDER NAME and ADDRESS.** Enter Provider Name and Address, including ZIP code.
3.	**PROVIDER NUMBER.** Enter the complete (9-digits) and correct Medi-Cal rendering provider number in this area or HAP provider number (FQHC, RHC, LA Waiver). When requesting authorization for an elective hospital admission, the hospital provider number must be entered in this box. (Enter the name of the hospital in the *Medical Justification* field. If this information is not present, the TAR will be returned to the provider unprocessed.)
4.	**PATIENT NAME, ADDRESS, TELEPHONE NUMBER.** Enter patient information in this space.

5. **MEDI-CAL IDENTIFICATION NO.** When entering the client's identification number from the Health Access Programs (HAP), begin in the farthest left position of the field. The county code and aid code must be entered just above the recipient *Medi-Cal Identification Number* box. Do not enter any characters (dashes, hyphens, special characters) in the remaining blank positions of the Medi-Cal ID field or in the *Check Digit* box.

Enter client's HAP identification number in the area identified for Medi-Cal identification number.

(34) (8H)

MEDI-CAL IDENTIFICATION NO.

5 | 12345678Y1

CHECK

DIGIT

County Code   **Aid Code**

Box 5 of TAR (50-1): (Leave Check Digit box blank.) This example also shows placement of the County Code and Aid Code on the form above Box 5.

6. **PENDING.** N/A

7. **SEX and AGE.** Use the capital "M" for male, or "F" for female. Enter age of the patient in the *Age* box.

8. **DATE OF BIRTH.** Enter the recipient's date of birth in a six-digit format. If the recipient's full date of birth is not available, enter the year of the recipient's birth preceded by "0101".

8A. **PATIENT STATUS.** Enter the patient's status. If the patient is an inpatient in a Nursing Facility Level A (NF-A) or Nursing Facility Level B (NF-B), enter the name of the facility in the *Medical Justification* field.

8B.   **DIAGNOSIS DESCRIPTION.** Always enter the English description of the diagnosis and its corresponding "S" diagnosis code. Refer to the *Family PACT: Diagnosis Codes Listings [familypact15]* section in this manual for "S" code information.

8C.   **MEDICAL JUSTIFICATION.** Provide sufficient medical justification for the consultant to determine whether the service is medically justified.

On line #1 include the phrase: "Family PACT client."

Note: Non-Family PACT (Referring Physician) TAR Completion

MEDICAL JUSTIFICATION. Non-Family PACT providers include the phrase "Family PACT client referred by (referring provider number affiliated with Family PACT).

If necessary, attach additional information. If the patient is an inpatient in a Nursing Facility Level A or B, enter the name of the facility in the *Medical Justification* field.

If the request is for a drug TAR, indicate in the *Medical Justification* field whether it is an initial, reauthorization or prescription limit request.

Providers using the fax process to request drug TAR authorization should include their fax number in the *Medical Justification* field (for example, FAX: (916) 555-1122). On requests submitted by a non-medical provider, the name and telephone number of the prescriber must appear in the lower left corner of this section (for example, Dr. John Smith (916) 555-1000).

9.   **AUTHORIZED YES/NO.** Leave blank. Consultant will indicate if the service line item is authorized.

10.   **APPROVED UNITS.** Leave blank. Consultant will indicate the number of times that the procedure, item or days have been authorized.

10A.   **SPECIFIC SERVICES REQUESTED.** Indicate the name of the procedure, item or service.

10B.   **UNITS OF SERVICE.** Leave blank.

11.   **PROCEDURE CODE OR DRUG CODE.** Enter the anticipated code (five-character HCPCS or five-digit CPT-4 [preceded by a zero and followed by a two-digit modifier when necessary]). When requesting hospital days, the stay must be requested on the first line of the TAR with the provider entering the word "DAY" or "DAYS".

12.   **QUANTITY.** Enter the number of times a procedure or service is requested, or the number of hospital days requested.

12A.   **CHARGES.** Indicate the dollar amount of your usual and customary charge for the service(s) requested.

13. – 32.   Additional TAR lines.

32A.   **PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS.** If applicable, enter the name and address of the patient's authorized representative, representative payee, conservator over the person, legal representative or other representative handling the beneficiary's medical and personal affairs.

33. – 36.   **FOR STATE USE.** Leave blank. Consultant's determination and comments will be entered in this section.*

           * Only submit your claim with the TAR if box 1 (Approved as Requested) or 2 (Approved as Modified) are marked. The *Denied* and *Deferred* boxes indicate that the provider's request has not been approved. The TAR must show the consultant's signature. If not, contact the Medi-Cal Field Office.

           The *Comments/Explanation* lines will list the approved procedures or any further information the provider must submit with the claim.

37. & 38.   **AUTHORIZATION IS VALID FOR SERVICES PROVIDED – FROM DATE/TO DATE.** Leave blank. Consultant will indicate valid dates of authorization for this TAR.

39.   **TAR CONTROL NUMBER.** Leave blank. The Medi-Cal Field Office consultant will enter a 2-digit prefix and a 1-digit suffix to the pre-imprinted 8-digit number. This entire 11-digit number must be entered on the claim form when this service is billed. The TAR Control Number serves as the initial admit TAR number for the hospital. This number will show that prior authorization has been obtained. Do not attach a copy of the TAR to the claim form.

39A.   **SIGNATURE OF PHYSICIAN OR PROVIDER.** Form must be signed by the physician or authorized representative.

40 – 43.   **F.I. USE ONLY.** Leave blank.